Individual Plans Summary

Provision	Plans A/50 - D				HMO	B&E (without riders)
	A/50	B	C	D		
Deductible options carriers *must* offer	$1,000 and $2,500 per person;					$50 per person - applies only to wellness
	$2,000 and $5,000 per family					
Deductible options carriers *may* offer	$5,000 and/or $10,000 per person				$1,000 or $2,500 per person	
	$10,000 and/or $20,000 per family				$2,000 or $5,000 per family	
Coinsurance paid by covered person	50%	40%	30%	20%	options for 50%, 40%, 30% 20%	30% for alcohol and substance abuse 30% for outpatient biologically based mental illness 20% for wellness
Maximum Out of Pocket	Deductible plus $5000	Deductible plus $3000	Deductible plus $2500	Deductible plus $2000	No greater than $5000	Not applicable
Emergency Room Copayment; (waived if admitted within 24 hours) Payable in addition to applicable deductible and coinsurance	$100	$100	$100	$100	$100	$100
Hospital Confinement Copayment; Payable in addition to applicable deductible and coinsurance	not applicable	$200/day; $1000/ confinement; $2,000/year	not applicable	not applicable	See copayment information below	See copayment information below
Copayments						
Hospital Confinement; maximum 5 copayments per confinement; maximum 10 copayments per year (maximums do not apply to B&E)	when offered as a PPO, carriers may use HMO copayments for network services				Carrier must offer:$150/day; Carriers may also offer $300, $400 and/or $500/day	$500 per person per period of confinement
Pre-Natal Care	when offered as a PPO, carriers may use HMO copayments for network services				$25 copayment /initial visit OR same copayment as applicable to physician visits; $0 thereafter	Not covered
All other services and supplies	when offered as a PPO, carriers may use HMO copayments for network services				Carriers must offer: $15/visit; Carriers may offer $30, $40 and/or $50/visit; Carriers may offer a split copay where there is a higher copay for specialist visits.	Not applicable
Lifetime Maximum Benefit	Unlimited				Unlimited	Unlimited

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Covered Charges/Covered Services and Supplies						
Hospital	Covered				Covered	Covered up to 90 days per year
Emergency and Urgent Care	Covered				Covered	Covered for emergency care
Pre-Admission Testing	Covered				Covered	Covered
Ambulatory Surgical Center	Covered				Covered	Not covered
Extended Care or Rehabilitation	Covered up to 120 days /year; requires pre-approval				Covered; requires pre-approval	Not covered
Home Health Care	Covered; requires pre-approval				Covered; requires pre-approval	Not covered
Hospice Care	Covered; requires pre-approval				Covered; requires pre-approval	Not covered
Practitioner Charges - surgical and non-surgical; second opinion	Covered				Covered	Covered up to $700; second opinion not covered
Preventive Care (Wellness in the B&E plan)	covered up to $500 per person per year; $750 for children through age 1 per year; Deductible and coinsurance do not apply				Covered	Covered up to $600 per person /year
Mammogram	Covered; age and frequency limits may apply				Covered	Diagnostic tests limited to $500/year
Colorectal cancer screening;	Covered; age limits may apply				Covered	Diagnostic tests limited to $500/year
Dialysis Center; dialysis treatment	Covered				Covered	Covered
Prescription drugs obtained while not in a hospital or other facility	Covered; coinsurance must continue to be paid even after maximum out of pocket has been satisfied; may require pre-approval				Covered subject to 50% coinsurance; may require pre-approval	Not covered
Supplies to administer prescription drugs	Covered				Covered	Not covered
Alcohol Abuse	Covered				Covered	30 days inpatient; 30 visits outpatient; combined with substance abuse
Biologically-based mental illness	Covered				Covered	90 days inpatient; 30 visits outpatient
Non-biologically-based mental illness and substance abuse	Covered; limited to 30 days/year inpatient; 20 visits outpatient; exchange of unused inpatient days requires pre-approval				Covered; limited to 30 days/year inpatient; 20 visits outpatient; exchange of unused inpatient days requires pre-approval	for substance abuse, see alcohol abuse above; non bio-based mental illness not covered

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Pregnancy	Covered				Covered	Covered only for charges for the delivery of the child and the use of the delivery room
Birthing Center	Covered				Covered	Not covered
Newborn child coverage	Covered first 31 days; thereafter must add child to policy				Covered first 31 days; thereafter must add child to policy	Covered first 31 days; thereafter must add child to policy
Specialized infant formulas	Covered				Covered	Not covered
Immunizations and lead screening	Covered; deductible does not apply				Covered	Covered
Newborn hearing screening	Covered; limited benefit				Covered; limited benefit	Not covered
Anesthesia	Covered				Covered	Covered
Blood	Covered				Covered	Covered
Ambulance	Covered				Covered	Not covered
Durable Medical Equipment	Covered; requires pre-approval				Covered	Not covered
Nutritional Counseling	Covered; requires pre-approval				Covered	Not covered
Food and food products for inherited metabolic disease	Covered				Covered	Not covered
X-rays and laboratory tests	Covered				Covered	Covered
Dental care and treatment	Covered; limited to tumors, cysts, bony impacted teeth, injury to teeth or jaw				Covered; limited to tumors, cysts, bony impacted teeth, injury to teeth or jaw	Not covered
TMJ	Covered; surgical and non-surgical; excludes orthodontia, crowns, bridgework				Covered; surgical and non-surgical; excludes orthodontia, crowns, bridgework	Not covered
Prosthetic Devices	Covered; requires pre-approval				Covered	Not covered
Physical therapy	covered; limited to 30 visits /year; may require pre-approval				Covered; limited to 30 visits / year	$20 copay per visit; limited to 30 visits /year
Occupational Therapy	covered; limited to 30 visits /year; may require pre-approval				Covered; limited to 30 visits / year	Not covered
Speech therapy	covered; limited to 30 visits /year; may require pre-approval				Covered; limited to 30 visits / year	Not covered
Cognitive rehabilitation therapy	covered; limited to 30 visits /year; may require pre-approval				Covered; limited to 30 visits / year	Not covered
Chelation therapy	Covered				Covered	Not covered
Chemotherapy	Covered				Covered	Not covered
Radiation therapy	Covered				Covered	Covered
Respiration therapy	Covered				Covered	Not covered
Vision screening	Covered; limited benefit; eye exams not covered				Covered; limited benefit; eye exams not covered	Not covered
Therapeutic manipulation	covered; limited to 30 visits /year				Covered; limited to 30 visits /year	Not covered
Transplant benefits	Covered; specified procedures only				Covered; specified procedures only	Not covered
Surgical treatment of morbid obesity	Covered; specific criteria must be met				Covered; specific criteria must be met	Not covered